# State of Delaware: Highmark Comprehensive PPO

**Coverage Period: 07/01/2017 - 06/30/2018**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual + Family | **Plan Type:** PPO

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage you can visit **www.highmarkbcbsde.com** or by calling **1-844-459-6452**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.highmarkbcbsde.com** or by calling **1-844-459-6452** to request a copy

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: **$0**; Out-of- Network: **$300** person/**$600** family. Doesn't apply to preventive care, copayments or prescription drugs. Balance billing and excluded services do not count toward the **deductible**. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services | This plan covers preventive care services, even if you have not met the deductible amount. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit for this plan?** | Yes. In-Network Medical: **$4,500** person/**$9,000** family; In-Network Prescription Drug: **$2,100** person/**$4,200** family. Out-of-Network Medical: **$7,500** person/**$15,000** family; Out-of-Network Prescription Drug: No out-of-pocket limit. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance billing, health care this plan does not cover, bariatric surgery expenses and infertility expenses. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. For a list of in-network **providers**, see **www.highmarkbcbsde.com, call 1-844-459-6452**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do you need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What Will You Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay | 20% coinsurance | -- None -- |
| | Specialist visit | $30 copay | 20% coinsurance | -- None -- |
| | Preventive care/screening/ immunization | No charge | 20% coinsurance | Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to **www.highmarkbcbsde.com** or call **1-844-459-6452** for specific information. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab: $10 copay; X-Ray: $20 copay; Machine Testing: No Charge | 20% coinsurance | -- None -- |
| | Imaging (CT/PET scans, MRIs) | No charge at freestanding facilities; $35 copay at hospital-based facilities | 20% coinsurance | Prior authorization required. Failure to pre-authorize will result in a denial. |

| Common Medical Event | Services You May Need | What Will You Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.express-scripts.com. | Generic drugs | $8 copay for 30-day supply retail or mail order; $16 copay for 90-day supply participating retail or mail order | Reimbursement limited to in-network allowable amount minus applicable copay | Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless medically necessary for conditions other than ED. Prescription drugs with an over-the-counter equivalent are not covered. |
| | Preferred brand drugs | $28 copay for 30-day supply retail or mail order; $56 copay for 90-day supply participating retail or mail order | Reimbursement limited to in-network allowable amount minus applicable copay | |
| | Non-preferred brand drugs | $50 copay for 30-day supply retail or mail order; $100 copay for 90-day supply participating retail or mail order | Reimbursement limited to in-network allowable amount minus applicable copay | |
| | Specialty drugs | Copay based on whether drug is generic, preferred, or non-preferred | Not covered | First fill can be at retail; future fills must be through specialty pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Outpatient Hospital: $100 copay per visit; Ambulatory Surgery Center: $50 copay per visit | 20% coinsurance | -- None -- |
| | Physician/surgeon fees | No charge | 20% coinsurance | -- None -- |
| **If you need immediate medical attention** | Emergency room care | $150 copay (waived if admitted) | $150 copay (waived if admitted) | Care must be rendered within 48 hours of onset of symptoms. |
| | Emergency medical transportation | No charge | No charge | -- None -- |
| | Urgent care | $20 copay per day | 20% coinsurance | -- None -- |

| Common Medical Event | Services You May Need | What Will You Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $100 copay per day with $200 maximum per admission | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| | Physician/surgeon fees | No charge | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| **If you have mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay | 20% coinsurance | -- None -- |
| | Inpatient services | $100 copay per day with $200 maximum per admission | 20% coinsurance | Pre-authorization required. Failure to preauthorize will result in a denial. |
| **If you are pregnant** | Office visits | No charge | 20% coinsurance | -- None -- |
| | Childbirth/delivery professional services | No charge | 20% coinsurance | -- None -- |
| | Childbirth/delivery facility services | $100 copay per day with $200 maximum per admission | 20% coinsurance | -- None -- |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 20% coinsurance | Coverage is limited to 240 visits per plan year. Pre-authorization required. Failure to pre-authorize will result in a denial. |
| | Rehabilitation services | 15% coinsurance; No charge for applied behavioral analysis (ABA) | 20% coinsurance | ABA limited to $36,000 per person per plan year to age 21. |
| | Habilitation services | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Skilled nursing care | No charge | 20% coinsurance | Coverage is limited to 120 days per benefit period. Benefits renew after 180 days without care. Pre-authorization required. Failure to pre-authorize will result in a denial. |

| Common Medical Event | Services You May Need | What Will You Pay | | Limitations, Exceptions & Other Important Information |
|---|---|---|---|---|
| | | In-network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| | Durable medical equipment | No charge | 20% coinsurance | -- None -- |
| | Hospice services | No charge | 20% coinsurance | Coverage is limited to 365 days. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Children's glasses | Not covered | Not covered | You must pay 100% of these expenses, even in-network. |
| | Children's dental check-up | No charge under Delta Dental or Dominion Dental | 20% coinsurance under Delta Dental; not covered under Dominion Dental | Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Eye exam
- Glasses
- Habilitation services
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids (up to age 24)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-459-6452. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or www.highmarkbcbsde.com. Additionally, a consumer assistance program can help you file an appeal. Contact The Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or consumer@state.de.us.

### Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Notice of Nondiscrimination

**Discrimination is Against the Law**

The State of Delaware Group Health Insurance Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The State of Delaware Group Health Insurance Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The State of Delaware Group Health Insurance Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Brenda Lakeman.

If you believe that The State of Delaware Group Health Insurance Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage, at Office of Management and Budget (OMB), Statewide Benefits, 97 Commerce Way, Suite 201, Dover, DE 19904, phone: 1-800-489-8933, fax: 1-302-739-8339, and email: benefits@state.de.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Brenda Lakeman, Director of Statewide Benefits and Insurance Coverage is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

### Language Access Services:

Arabic (العربية): 1-800-489-8933 اتصل برقم. إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان

Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-489-8933.

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-489-8933.

French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.

Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-489-8933.

Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-489-8933 まで、お電話にてご連絡ください。

Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-489-8933 번으로 전화해 주십시오.

Persian-Farsi (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-489-8933 تماس بگیرید

Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-489-8933.

Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-489-8933.

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-489-8933.

Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-489-8933.

Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-489-8933.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$460** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,060** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Other:** Based on type of service

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,000** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $200 |
| Coinsurance | $30 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$230** |

The plan would be responsible for the other costs of these EXAMPLE covered services.